Care Quality Commission

Cheriton Nursing Home Limited

Springfield Court Care Centre

Inspection report

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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Good**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Good**

Overall summary

Springfield Court Care Centre provides accommodation which includes nursing and personal care for up to 45 older people. At the time of our visit 40 people were using the service. The home has two levels, with a dementia care unit for up to five people situated on the ground floor. There were communal lounges on each floor with a central kitchen and laundry. When we inspected the dementia care unit, we saw a great deal of work and effort had taken place since the unit opened to create a dementia friendly environment.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We found the service to be well led.

Where plans contained information and guidance for staff on how to provide care and support, it was not always

Summary of findings

clear if this guidance was followed. We found in some care plans that documents were incomplete. This meant there was a risk that people may not always receive care that was responsive to their needs

There were sufficient numbers of staff on duty in order to meet the needs of people using the service. The provider had an effective recruitment and selection procedure in place and carried out appropriate checks when they employed staff. We found staff treated people with dignity, respect, kindness and compassion.

Staff understood their responsibilities and the actions they needed to keep people safe from harm and abuse. We saw evidence that thorough investigations had been carried out in response to safeguarding incidents or allegations and these had also been reported to CQC by the provider.

We saw staff supporting people in the dining rooms at lunch where a variety of choices of food and drinks were being offered. Where required specialist diets were available such as pureed or fortified foods. People spoke positively about the food choices available to them.

The home had a programme of activities in place for people, including meaningful activities for people living with dementia. We saw people were encouraged and supported to remain independent where they could. The director of nursing told us of their future plans with supporting people to maintain their independence. This will involve people being able to make their own drinks and where they want to help with domestic chores.

Training records were up to date. Staff received regular supervisions and appraisals, where they could discuss personal development plans, which meant that staff were properly supported to provide care to people who used the service.

Arrangements were in place for keeping the home clean and hygienic and to ensure people were protected from the risk of infections. During our visit we observed that bedrooms, bathrooms and communal areas were clean and tidy and free from odours.

Staff acted in accordance with the requirements of the Mental Capacity Act 2005. Where people did not have the capacity to make the decisions themselves, mental capacity assessments were in place and records showed that decisions had been made in line with best interests. Where required Depravation of Liberty Safeguarding applications had been submitted by the registered manager.

The registered manager investigated complaints and concerns. People, their relatives and staff were supported and encouraged to share their views on the running of the home. The provider had quality monitoring systems in place. Accidents and incidents were investigated and discussed with staff to minimise the risks or reoccurrence.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
This service was safe.

Good

The registered provider had systems in place to manage risks safely, safeguarding matters, staff recruitment and medication and this ensured people's safety.

There were systems in place to reduce the risk and spread of infection. Staff understood their role for maintain high standards of cleanliness and hygiene. People told us their rooms were cleaned daily.

There were enough competent staff on duty who have the right mix of skills and experience to ensure they can safely meet the needs of people using the service.

Is the service effective?
This service was effective.

Good

People's nutritional needs were assessed and monitored to identify any risks associated with nutrition and hydration. People spoke positively about the food choices available to them.

We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards. People's best interests were managed appropriately under the Mental Capacity Act (2005).

Staff were well supported through training and development and had the right skills and knowledge to meet people's assessed needs.

Is the service caring?
This service was caring.

Good

Staff knew the people they were caring for and supporting, including their personal preferences and personal likes and dislikes.

People told us they were treated with kindness and compassion and their privacy and dignity was always respected. Staff responded in a caring way to people's needs and requests.

People had access to advocacy services. This enabled others who knew them well to speak up on their behalf.

Is the service responsive?
This service was responsive.

Requires improvement

Summary of findings

Where plans contained information and guidance for staff on how to provide care and support, it was not always clear if this guidance was followed. We found in some care plans that documents were incomplete. This meant there was a risk that people may not always receive care that was responsive to their needs.

People and/or their relatives said they were able to speak with staff or the managers if they had any concerns or a complaint. They were confident their concerns would be listened to and appropriate action taken.

People were encouraged and supported to follow their interests. Activities were available within the home should people wish to take part.

People were supported to maintain relationships with people that mattered to them. People told us their relatives and friends could visit anytime. We saw visitors arriving throughout both days of our inspection.

Is the service well-led?

Good

This service was well led.

There were clear values that included treating people with dignity and respect and supporting people to remain independent. There was an open culture and staff told us they felt supported by management.

The management team had effective systems in place to assess and monitor the quality of the service, the quality assurance system operated to help to develop and drive improvement.

The service worked in partnership with key organisations, including specialist health and social care professionals.

Springfield Court Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 November and 1 December and was unannounced. Two inspectors and an expert by experience carried out this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. During our last inspection in February 2014 we found the provider satisfied the legal requirements in the areas that we looked at.

Before we visited we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with twelve people who use the service and two visiting relatives about their views on the quality of the care and support being provided. During our inspection we observed how staff interacted with people using the service. We used the Short Observational Framework for Inspection (SOFI). We used this to help us see what people's experiences were. The tool allowed us to spend time watching what was going on in the service and helped us to record whether they had positive experiences.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included nine care and support plans, staff training records, staff duty rosters, staff personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for part of the day.

During our inspection we spoke with the registered manager, the director of nursing and eleven staff including nurses, housekeeping staff, the maintenance person and the chef. We also spoke with a visiting health professional.

Good

Is the service safe?

Our findings

People and their relatives told us they or their relative felt safe living in Springfield Court Care Home. Comments included "I'm happy here. I sleep better here than at home. At home I was always listening out. Here someone else does the worrying", and "I've made friends with a lady called X. I go down to X's room to see her. I doddle along with my walking frame and the girls watch me to see that I'm safe. I ring when I want to go and see X or go to the loo" One person told us "Moving into Springfield Court was a good move. I like the fact there's people in and out all the time, I'm not left for hours on end on my own". People told us they knew who to speak to if they felt worried or had a problem.

Policies were in place in relation to safeguarding and whistleblowing procedures which guided staff on any action that needed to be taken. Records showed staff had received training in safeguarding adults. This was also part of new staff member's essential training during induction. All the staff we spoke with had a good understanding of the correct reporting procedure. Staff were aware of their responsibilities; they were able to describe to us the different types of abuse and what might indicate that abuse was taking place. Staff were able to tell us about the provider's whistleblowing policy and how to use it. Staff told us they were actively encouraged by managers to raise concerns about working practices and said they felt concerns raised would be treated confidentially. They were confident that any reports of abuse would be acted upon appropriately. The registered manager and director of nursing were very clear about when to report concerns and the processes to be followed to inform the local authority, police and CQC.

Care records showed that people's individual needs were assessed before admission into the home and where risks were identified appropriate guidance was in place to minimise potential risks. For example the provider had carried out assessments in relation to falls prevention, malnutrition and the safe moving of people. Personal fire evacuation plans had been completed for people using the service.

People's medicines were managed so they received them safely. Each person using the service had their own locked medicine cupboard in their bedroom. Staff accessed the cupboard to dispense medicines in accordance with the prescription. Medicines were given on time, and the nurse administering the medicines knew people well and the reasons why the medicines had been prescribed. They asked people if they were happy to have their medicines and asked them how they preferred to take them. Although people's preferences in relation to taking their medicines were not recorded on the front of the medicines administration record (MAR), the staff knew how people liked to take them. For example, the nurse asked one person "I know you like your tablets after breakfast; have you had your breakfast yet?" and "Shall I give them to you one by one?" The nurse asked people if they required any pain relief, ensured people had a drink to hand, and didn't rush people.

One person using the service was self-administering their inhaler. Forms in relation to the assessment of this person's ability to do so safely and effectively were in place, and had been dated and signed by staff and the person. One person had recently been receiving their medicines covertly. This is when medicines are disguised in food or drink. The documentation in relation to the decision to administer covertly was completed in full. However, the documentation that should have been completed by the pharmacist was not. Although the pharmacist had signed their agreement, there was no information on how the medicines should be given in order to preserve their action. The nurse did know this information, but it was not documented, which meant there was a risk that other staff administering the medicines could give them incorrectly. The registered manager said they would rectify this.

When medicines were no longer required, there was a 'destruction' process in place. However, although some pages of the destruction log contained two staff signatures, the later pages only contained one. The earlier pages had a column for a witness to sign, but this was missing on the most recent pages. The nurse was unclear why this was. The registered manager was also unclear and said they would rectify this with immediate effect.

Short medicine audits were completed weekly and more in-depth audits were completed monthly. There was a recurring theme noted from the audits on 26/11/2015, 13/10/2015 and 15/09/2015 that nurses were not documenting on the back of MAR charts the reasons for administering PRN medicines and that staff had been repeatedly reminded of their responsibilities in relation to this. The

Good

Is the service safe?

MAR charts we saw did contain notes of when and why PRN medicines had been given. The last pharmacist audit had been undertaken during February 2015, and no concerns were raised.

We saw safe recruitment and selection processes were in place. We looked at the files for six of the staff employed and found that appropriate checks were undertaken before they commenced work. The staff files included evidence that pre-employment checks had been made including written references, satisfactory Disclosure and Barring Service clearance (DBS) and evidence of their identity had also been obtained. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Most people who lived at the home felt there were adequate numbers of staff to meet their needs.During our inspection we saw there were sufficient staff to support people in the different areas of the home. We noted call bells were answered quickly and people did not have to wait long periods of time for assistance to be provided. One person told us "I use it (call bell) when I want a late night drink. Sometimes they come quickly. It depends on who's in and who else needs help. I rang the emergency bell once and they came as quickly as they should have done". Staff we spoke with told us there was enough staff on duty to meet people's needs. In an emergency, bank staff were called in to cover staff shortages, due to holidays or illness. Staff from the provider's other homes were also used to provide cover.

Measures were in place to maintain standards of cleanliness and hygiene in the home. For example, there was a cleaning schedule which all housekeeping staff followed to ensure all areas of the home were appropriately cleaned. Bedrooms and communal areas were clean and tidy. The service had adequate stocks of personal protective equipment such as gloves and aprons for staff to use to prevent the spread of infection. People and their relatives told us they were happy with the standard of cleanliness in the home.

Good

Is the service effective?

Our findings

People we spoke with told us they had confidence in the abilities of staff. Comments included ""I trust the advice they give me. I was poorly the other day and one of the carers suggested I stayed in bed. It was the best thing for me" and "The staff are very good. The manager is very good. I raised some concerns I had and she responded straight away".

Records and certificates of training showed that a range of learning opportunities were provided for all staff. These included areas such as the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), fire awareness, food hygiene, moving and handling, infection control, safeguarding adults and health and safety. Staff had also completed additional learning in relation to the specific needs of those who lived at the home, for example, dementia awareness. Newly appointed care staff went through an induction period which included shadowing an experienced member of staff. The staff we spoke with were positive about the training and felt it supported them to be able to carry out their duties correctly.

Nursing staff had access to continuing professional development. The registered manager had also provided the nurses with information in relation to their responsibilities for revalidation with the Nursing and Midwifery Council (NMC). This is a process that has been recently introduced to ensure that nurses undertake a specified number of hours of training in relation to their role, including reflection and feedback from people to ensure they are safe to practise as a nurse.

The nurses said they had attended training recently, such as venepuncture (taking blood samples), medication updates and wound care. They also had access to specialist training from the local hospice and hospital. Both of the nurses were knowledgeable about their role and responsibilities and both had the relevant skills to perform their role.

When we spoke with staff, they told us they received regular supervision meetings with their line manager. These meetings were used to discuss progress in the work of staff members; training and development opportunities and other matters relating to the provision of care for people living in the home. These meeting would also be an opportunity to discuss any difficulties or concerns staff had.

We spoke with a recently appointed member of staff who said "The staff are all very supportive and I can ask questions. I feel I am learning something every day". Staff said they felt supported by both the registered manager and director of nursing. They said they could approach them at any time to seek guidance and support. They also said they could seek support and advice from other staff members. Staff also told us they could approach the owner of the home with any concerns they may have.

Nurses said they received supervision sessions from the registered manager every three months, and had a formal appraisal annually. They also said they were about to implement nurse meetings in order to share best practise amongst the nursing team.

People spoke very highly about the meals provided. Comments included "We're very fortunate with the food. We seem to have a good cook"; "I have breakfast in bed. I ask what's on offer and I choose from that" and "They will always get you what you want. I asked for Weetabix and prunes for breakfast and they got me them".

We observed people eating their midday meal and saw they were offered various meal choices, which included a vegetarian option. If a meal was declined staff offered alternatives and encouraged people to eat. One person said they wanted something different and would like some soup, within minutes this was provided. Meals were attractively presented and vegetables were in dishes on the table so people could help themselves. There was a relaxed, sociable and unhurried atmosphere. People were offered hot or cold drinks and were encouraged to eat sufficient amounts to meet their needs. Everyone we spoke with said the meals were very good. Where required people were offered assistance to eat their meals. Staff asked people "Would you like me to cut it up for you?" and "Would you like it on your lap or on the table?

Throughout our visit, we noted people, whether in their rooms or in the lounge always had drinks within easy reach. We saw staff prompt and help people who had difficulty in drinking unsupported. Staff provided hot and cold drinks and snacks at any time. Specialised cutlery and cups were available to support people to maintain their independence with eating and drinking.

People had access to specialist diets when required for example pureed or fortified food. We spoke with the chef; they had information of all people's dietary requirements

and allergies. This also included people's likes and dislikes. They explained that people had a choice of meals. They said if people did not like what was on the menu then they were able to request alternatives. The kitchen was clean and tidy and had appropriate colour coded resources to ensure that food was prepared in line with food handling guidance.

People told us staff supported them to see a health professional such as a doctor or optician when they needed to. One person said "When I wasn't well they got me to hospital". A GP visited once a week and there was also evidence to show care staff would act appropriately when a person's health condition changed. Contact with health professional was recorded in people's daily records which showed people's day-to-day health needs were met. It was also evident from care files that people were referred to relevant professionals such as Speech and Language Therapy. A visiting health professional spoke positively about the care and support people received. They said that communication between themselves and the home was very good. They felt staff knew people well and would contact the surgery when required if someone was not feeling well. They said "People are well cared for, staff spend time talking to people to find out what is wrong".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interest and as least restrictive as possible.

Where people did not have the capacity to make decisions for themselves, mental capacity assessments were in place and decisions made in the person's best interest were documented. During the inspection, the registered manager told us they were needed they had made applications for DoLS authorisations. Applications had been submitted by the provider to the local authority and they were awaiting a response.

Staff demonstrated a good understanding of supporting people to make choices .Staff were observed throughout the inspection asking people's consent before they assisted them. They asked people "Who would like some music on?" and "What type of music would you like?" as well as "Would you like me to help you with that?" Nursing staff understood the principles of the Mental Capacity Act and the process of getting an authorisation for deprivation of liberty.

Good

Is the service caring?

Our findings

People and their relatives spoke positively about the care and support they or their relative received. Comments included "Staff pop in to say hello or goodnight", "I have to be hoisted, I have to be washed in bed every day but the girls are very good, they don't make me feel uncomfortable" and "most of the staff are very obliging and helpful. They are so kind, they go out of their way to make us happy, and we all get on together".

Staff had positive relationships with the people they were supporting. Staff were respectful and caring in their approach to supporting people. Where people needed assistance staff sought their permission before assisting them, explained what they were doing and offered reassurance throughout the task. For example we saw staff transferring one person from their wheelchair in to an armchair using a hoist. Two staff did this and constantly checked with the person as they moved them saying "X, are you OK there?" We asked the person if they felt safe when they were being hoisted and they said that staff talked to them throughout and there had never been any near misses. They said "They're (staff) watching you all the time".

One person asked, "Can you turn it (music) up please?", which staff did straightaway. They checked with the person saying "X, can you hear it now?" The person became a little tearful at this point. Staff asked "Do you want it turned off if it's upsetting you?" but the person said that they were "happy tears" because the song was special to them.

We saw staff responded in a caring way to difficult situations. For example, when a person became agitated during lunch, we saw staff sitting with them and talking with them in a calm, reassuring quiet way which helped to settle the person. They asked the person if they would like to sit somewhere else which the person agreed to.

We saw staff promoted people's privacy and dignity. Staff knocked on people's doors and waited to be asked in. Any care and support was conducted behind closed doors. Staff told us when supporting people with any personal care they would always ensure this was done with the person's door closed and the curtains drawn. They would always introduce themselves and explain what was happening. They said they would encourage the person to do as much for themselves as they could. They said they would always ensure that people were covered when supporting with intimate tasks. One staff member said "It's important to offer people reassurance and check they are OK when completing personal care".

People were supported to be independent and were encouraged to do as much for themselves as possible. One person told us that during personal care staff encouraged them to do as much for themselves as they felt able. They told us staff escorted them on their visits to another person's room rather than pushing them there in a wheelchair. Some people used equipment, such as walking frames, to maintain their independence. Staff ensured people had the equipment when they needed it and encouraged people to use it.

Staff were knowledgeable about the care and support people required. For example if people preferred a bath or shower or what clothes they liked to wear. One person told us "They get something out of the wardrobe and say, Is this alright? and I might say Oh no, not that and they get something else out".

We observed the lunch time meal which was calm and unhurried. Staff frequently checked with People to ensure they were assisted to eat at their own pace. For example asking "Is this too hot for you?", and "Let me know when you're ready for the next one (spoonful)". A staff member explained to one person who they were preparing a thickened drink for "I'm just letting it thicken up a bit", so they were aware of why they were waiting.

Requires improvement

Is the service responsive?

Our findings

The service was currently providing an 'assess to discharge' service for people leaving hospital who would be returning home. This meant the home had different paperwork for this service and for people using the long term service.

Care plans for people using the access to discharge service sometimes lacked detail. For example, in one person's plan it stated they needed assistance with eating and drinking but did not contain any guidance for staff on how to assist the person. The registered manager explained there were discharge support plans from the hospital which contained this information. However, information in these plans was not always easy to find. As people using this service were only with the home short term they explained that full care plans were not completed. The registered manager explained this was initially only a short term contract which was due to expire in December 2015. If this contract was renewed then they agreed the paperwork would be reviewed and more detail included.

People living in the home long term had comprehensive care plans which contained information and guidance for staff on how to provide care and support. There were some good examples of how staff had gained information and detail to identify people's preferences. One staff member described how they recognised when a person, who was unable to communicate, was upset, and when they wanted the bathroom. The plan reflected what the staff member had described. We observed one person who was doing some drawing. Staff told us this person liked to draw and we saw this had been included in their care plan.

Where plans contained information and guidance for staff on how to provide care and support, it was not always clear if this guidance was followed. For example, we looked at three position change charts. Of the three, one person had a pressure sore and two had been assessed as being at high risk of skin breakdown. The care plan for the person with a pressure sore informed staff to "Monitor daily". A wound assessment was in place, and they had a pressure relieving mattress in situ but there was no information for staff on how often their position should be changed to prevent the wound deteriorating. The position chart also did not contain this information. The chart indicated that the person had been in the same position on 28/11/2015 from 15.00 hours to 21.00 hours and on 29/11/2015 from 05.00 hours to 10.00 hours and from 10.30 hours to 15.00 hours. Position changes are important in the prevention of skin breakdown and to aid the healing process.

Another person's chart also did not state the frequency of required position changes, although one member of staff said it should be "Four hourly" which reflected the guidance in the care plan; however, the chart showed that on 27/11/2015 the person's position had not been changed from 14.00 hours to 21.00 hours, and on 29/11/205, no change was recorded from 04.00 hours to 12.00 midday which would indicate that the care plan was not being followed.

The third person's care plan stated they had a "Red sacrum". This chart also did not specify the frequency of position changes, and indicated that on the 22/11/2015 they had not had their position changed from 07.00 hours to 21.00 hours. On four other dates there were no entries for up to seven hours at a time. This meant there was a risk that people did not always receive care that was responsive to their needs.

We found in some care plans that documents were incomplete. For example, although some plans contained mental capacity assessments and best interest decision details not all had been reviewed regularly. In one person's plan, a completed mental capacity assessment was in place that stated the person had been assessed as lacking capacity. A bed rails risk assessment had been completed, and input from the person's next of kin had been documented prior to fitting the bed rails. However, the form was dated 11/04/2015 and stated that the decision should be reviewed monthly. However, there was no evidence of this review taking place. Another person's mental capacity assessment had been started, but was not completed.

When we inspected the dementia care unit which was opened in July 2014. We saw that a great deal of work and effort had taken place since the unit opened to create a dementia friendly environment. Each bedroom had a memory box on the wall that was personal to the occupant. Doors were painted different colours to help people to recognise their own bedroom and the bathrooms. There was a corridor which the director of nursing and registered manager had furnished with furniture that created a 'memory lane' for people using the service.

Requires improvement

Is the service responsive?

We conducted our SOFI observation on the dementia care unit. We saw staff interacted very positively with people in a friendly and supportive manner, addressing them by name and showing they were fully aware of individual's likes and dislikes. Staff members were pleasant and had a caring approach towards people who were living with dementia. Staff continued to chat with people, whilst assisting them with personal care. We saw staff responded to people's requests for assistance promptly.

The home had an activity co-ordinator who organised activities throughout the week. They also offered people activities on an individual basis. Activities included arts and crafts, quizzes and day trips out. They also invited outside entertainment to come in to the home to perform. The activities co-ordinator told us it was people's choice if they wished to join in. We also spoke with an external therapist who provided activities weekly within the home. They said staff were very enthusiastic about getting involved and supporting people to access activities. For example they told us about one person who wanted an advent calendar. Staff had expressed a wish to the therapist to go and purchase this as they wanted to ensure the person had a calendar they knew they would like.

The director of nursing told us about a virtual cruise people had taken part in during the year. Each time the virtual ship docked in a country the home held a themed day which included food and entertainment. This had taken place each month and had included a pyramid cake for Egypt and a fish and chip evening for England. They would be finishing their virtual cruise in New York on New Year's Eve.

There was a procedure in place which outlined how the provider would respond to complaints. There were notice boards around the home which displayed information for people on how to make a complaint and how to get in touch with advocacy services. People told us they knew what to do if they were unhappy with any aspects of care they were receiving. They said they felt comfortable speaking with the registered manager or a member of staff. We looked at the complaints file and saw that all complaints had been dealt with in line with the provider's procedure. One person told us "I'd talk to the Manager, she's always about". Another person said that they had complained (could not remember who to) about a staff member's attitude and had noticed that this had improved lately.

Good

Is the service well-led?

Our findings

There was a registered manager in post who was supported by the director of nursing. People knew the management team and told us they felt comfortable speaking with them. Staff told us the registered manager and director of nursing were approachable and they felt part of a team. They said they could raise concerns and were confident any issues would be addressed appropriately. Staff told us they felt well supported in their role and that they did not have any concerns. All staff spoken with provided positive feedback about the management team.

Staff were aware of the organisations visions and values. Staff all had cards which set out the 'principles of care' within the home. Principles included 'you must tell residents what you are about to do for them' and 'you must offer residents a choice of food and drink at all time'. We saw that staff adhered to these principles during our inspection. Staff told us their role was to ensure people's privacy and dignity was considered and to promote independence and choice.

Concerns or issues could be discussed in staff's one to one meetings or raised at team meetings. Staff told us team meetings were an opportunity for them to discuss ideas and make suggestions as to how they could improve the service.

The registered manager and director carried out audits to assure themselves of the quality and safety of the service people received. Whenever necessary, action plans were put in place to address the improvements needed. Before the inspection the registered manager had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They and the director of nursing said they had found completing this very useful and had drawn up an action plan based on the improvements they had included on this form. The registered manager understood their responsibilities of registration with us and notified us of important events that affected the service.

Audits of call bells were carried out. The registered manager explained they had used this information to find out why a person had been regularly using the bell early in the morning. It transpired this person had previously had to get up early due to the job they held. This had been identified as a potential reason for them using the call bell early in the morning. Staff were made aware of this and to support the person should they wish to get up at this time.

Staff members' training was monitored by the registered manager to make sure their knowledge and skills were up to date. There was a training record of when staff had received training. The director of nursing explained that in the new year they were going to complete a training matrix of training staff had completed which would also identify when they should receive refresher training. Staff told us they received the correct training to assist them to carry out their roles.

Accidents and incidents were monitored to identify any patterns or trends. We saw the registered manager had taken action to ensure staff were reminded during handovers to ensure that sensor mats were in the correct place in people's rooms. Accidents and incidents were discussed at the team meetings to minimise the risk of reoccurrence.

People and their relatives were encouraged to give their feedback on the service and this was acted upon. From a recent survey it was noted that people felt the answering of call bells had improved. There was a 'residents council' meeting held periodically throughout the year. These meeting were used to discuss activities people would like and offering feedback on the menus. Recent feedback had been given to the chef who was using this information to plan new menus.

To keep up to date with best practice the registered manager and director of nursing attended local care home provider forums. This gave them the opportunity to meet with other providers to share best practice and discuss challenges they may be facing with service delivery. They also worked alongside the local hospice.

We discussed the improvements they would like to make in the coming year. This included ensuring people all had a 'Getting To Know Me' document completed in their care plans. We saw this had been completed for those people living in the dementia unit. They also wanted to look at 'up skilling' people and promoting their independence more. They wanted people to be more involved in the running of the home and where possible doing more things for

Good

Is the service well-led?

themselves, for example making their own drinks or assisting to clean their rooms. The provider was also looking at renovating the garden so that people could access it independently.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.